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Member American Association of Orthodontists

WELCOME

Patient Information

Name of Child______________________________________Nickname___________________________
Sex: M ____F _____Age____ DOB __________ School ___________________________ Grade______
Home Address ____
Home Phone _____________ Musical Instrument Played_______________________________________
Sports And /Or Hobbies____
Names and ages of brothers and sisters____
Whom may we thank for referring you ____

Parent's/Guardian's Information

Father's/Guardian's Name ___________________
Address (if different) _______________________
____
Home Phone ______________________________
Cell # ______________Work # _______________
Email Address_____________________________
Social Security # _________________________
Birth date ________________________________
Employer ________________________________
Address__________________________________

Mother's/Guardian Name_____________________
Address (if different) _______________________
____
Home Phone ______________________________
Cell # _______________Work # _______________
Email Address ______________________________
Social Security # ____________________________
Birth date__________________________________
Employer __________________________________
Address______________________________________

Dental Insurance

Do you have dental insurance coverage? _____
Primary Subscriber________________________
Plan Name _______________________________
Phone Number____________________________
Group # ___________Policy #_____________

Secondary Subscriber _______________________
Plan Name _________________________________
Phone Number_______________________________
Group # ______________Policy #_____________

Dental History

Name of Dentist ____
Date of last visit to your dentist _________________ for what service ___________________
Does child brush teeth daily ____Yes ____No
Does your child floss daily ____Yes ____No
Is fluoride taken in any form ____Yes ____ No
Periodontal Treatment ____Yes ____No
Clicking or popping of the jaw ____Yes ____No
Grinding ____Yes ____No
Injuries to mouth, teeth or head ____Yes ____No
Does your child follow directions well _____
Does your child currently chew or smoke tobacco ____Yes ____No
Orthodontic appliances worn now or ever ____Yes ____No
Any family member had/has orthodontia ____Yes ____No Relationship________________________
Any unhappy dental experiences? ____
Does patient have any learning disabilities or need extra help with instructions? ___________________
Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.?
____

PLEASE COMPLETE BOTH SIDES

Medical History

Child's Physician ________________________ City/ State_____________________________________
Date of last physical examination ____________ Results _____________________________________
Is child under care of physician now? ____Yes ____No Ever been hospitalized? ____Yes ____No
Ever had surgery? ____Yes ____No Is there excessive bleeding when cut? ____Yes ____No
Are there any other medical conditions we should be aware of? _______If so please explain
____

Has your child had any history with any of the following? If yes, please mark with an x.

____Anemia ____Diabetes ____HIV/AIDS ____Sinus Problems
____Asthma ____Drug/Alcohol Abuse ____Kidney Disease ____Thyroid Disease
____Bladder Problems ____Epilepsy ____Liver Disease ____Tuberculosis
____Cancer ____Fainting ____Measles ____Glaucoma
____Cerebral Palsy ____Hearing Problems ____Mononucleosis ____Other
____Chicken Pox ____Heart Problems ____Mumps
____Convulsions ____Hepatitis ____Rheumatic Fever

Allergies or reactions to any of the following: If yes, please mark with an x.

____Local anesthetics (Novocaine or Lidocaine) ____Aspirin
____Ibuprofen (Motrin or Advil) ____Penicillin or other antibiotics
____Sulfa drugs ____Codeine or other narcotics
____Metals (jewelry, clothing snaps) ____ Latex (gloves, balloons)
____Vinyl ____Acrylic
____Animals
Foods_________________________________Other Substances_________________________________

Is the patient taking medication, nutrient supplements, herbal or non-prescription medicine? Please name them.
Medication ____________________________Taken for____
Medication ____________________________Taken for____
Medication ____________________________Taken for____

GIRLS ONLY
Has the patient started her monthly periods? ___________ If so approximately when? _______________
Is the patient pregnant? ______

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I hereby request that Dr. Charles M. Krowicki submit insurance forms on behalf of the above patient, and indicate on those forms that payment is to be made to the insured.

Signed:____ Date Signed:_____________________
Parent or Guardian

Signed:____ Date Signed:_____________________
Dental staff member